



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

METHODIST HOSPITAL
PO BOX 1866
FORT WORTH TX 76101

Respondent Name

Hartford Underwriters Insurance

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-13-0327-01

MFDR Date Received

October 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a compensable injury paid incorrectly."

Amount in Dispute: \$8407.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that The Hartford upholds the decision that payment was made appropriately in accordance with Rule 134.403."

Response Submitted by: Hartford Underwriters Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 17 to March 18, 2012	Outpatient Hospital Services	\$8407.76	\$8,407.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 27, 2012

- W1 – WORKERS COMPENSATION SATE FEE SCHEDULE ADJUSTMENT. PAYMENT OF SERVICES ARE INCLUDED IN THE VISIT RATE.
- 217 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON

INSURANCE CARRIER FAIR AND REASONABLE.

Explanation of benefits dated July 24, 2012

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. FINAL ACTION. IN ACCORDANCE WITH RULE 133.250(G).

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code J0840 has a status indicator of G, which denotes pass-through drugs and biologicals paid under OPPS; separate APC payment includes pass-through amount. These services are classified under APC 9274, which, per OPPS Addendum A, has a payment rate of \$2,111.36. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,266.82. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of \$1,254.41. The non-labor related portion is 40% of the APC rate or \$844.54. The sum of the labor and non-labor related amounts is \$2,098.95 multiplied by 13 units is \$27,286.35. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is \$27,286.35. This amount multiplied by 200% yields a MAR of \$54,572.70.
 - Procedure code J0840, date of service March 18, 2012, has a status indicator of G, which denotes pass-through drugs and biologicals paid under OPPS; separate APC payment includes pass-through amount. These services are classified under APC 9274, which, per OPPS Addendum A, has a payment rate of \$2,111.36. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,266.82. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of \$1,254.41. The non-labor related portion is 40% of the APC rate or \$844.54. The sum of the labor and non-labor related amounts is \$2,098.95 multiplied by 6 units is \$12,593.70. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is \$12,593.70. This amount multiplied by 200% yields a MAR of \$25,187.40.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75

- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.97. 125% of this amount is \$18.71
- Procedure code 80048, date of service March 18, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.98. 125% of this amount is \$14.97
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.02. 125% of this amount is \$13.78
- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.56. 125% of this amount is \$6.95
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.50. 125% of this amount is \$10.63
- Procedure code 85025, date of service March 18, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.02. 125% of this amount is \$13.78
- Procedure code 85610, date of service March 18, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.56. 125% of this amount is \$6.95
- Procedure code 85730, date of service March 18, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.50. 125% of this amount is \$10.63
- Procedure code 96365 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0439, which, per OPPS Addendum A, has a payment rate of \$126.76. This amount multiplied by 60% yields an unadjusted labor-related amount of \$76.06. This amount multiplied by the

annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of \$75.31. The non-labor related portion is 40% of the APC rate or \$50.70. The sum of the labor and non-labor related amounts is \$126.01. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$126.01. This amount multiplied by 200% yields a MAR of \$252.02.

- Per Medicare policy, procedure code 96375 may not be reported with procedure code 99284 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
 - Procedure code 96376 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 99284 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8003, for level II extended assessment and management services. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$219.00. This amount multiplied by 60% yields an unadjusted labor-related amount of \$131.40. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of \$130.11. The non-labor related portion is 40% of the APC rate or \$87.60. The sum of the labor and non-labor related amounts is \$217.71. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$217.71. This amount multiplied by 200% yields a MAR of \$435.42.
 - Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
3. The total allowable reimbursement for the services in dispute is \$80,547.69. The amount previously paid by the insurance carrier is \$1,363.42. The requestor is seeking additional reimbursement in the amount of \$8,407.76. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$8,407.76.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$8,407.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	May 22, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

_____	Martha Luévano	May , 2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812